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ABSTRACT

This summary report from a 3-year research and demonstration project describes the framework, methods and materials used by the University of Michigan-Ann Arbor Early Periodic Screening Diagnosis and Treatment (EPSDT) Day Care Project. The project served approximately 750 children and their families through day care centers and family day care homes in Washtenaw County, Michigan. The project developed a comprehensive and interdisciplinary approach to early health assessment and follow-through for children and training and consultation services for day care staffs. This approach involved adaptations of the EPSDT model and included on-site developmental assessment for each child served. Generally, the project demonstrated a means of enhancing preventive health care for young children by emphasizing the primary support day care centers can provide for families through promoting coordination of local resources for families using day care. (Author/RH)

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Summary Report
of the
Demonstration and Evaluation
for the
City/University
EPSDT Day Care Project

Edited by
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PS011618

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Special thanks go to the staffs of the day care centers which participated in our project. Their ideas, encouragement, and forbearance contributed much to the development of the project and its products.

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Many helpful and innovative training materials were developed which are useful for those involved in child care and service coordination: day care centers, day care homes, families, and the varied community services working on behalf of young children and their families. These materials are available through The University of Michigan, School of Education.

This project was supported in part by grant #11-P-90442/5-03, awarded by the Health Care Financing Administration (HCFA), DHEW, to The University of Michigan and the City of Ann Arbor through the Michigan Department of Social Services. The contents of the surveys and questionnaires are not the responsibility of HCFA.

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PREFACE

This summary report from a DHEW-funded three-year research and demonstration project describes the framework, methods, and materials used by the City-University EPSDT-Day Care Project. These can be adapted to assist others in their efforts to improve preventive health care for young children participating in day care and their families. This summary is a synthesis of a review of the project's demonstration activities and evaluation findings.

The City/University EPSDT-Day Care Project was a three-year research and demonstration project funded by DHEW to the Michigan Department of Social Services, and the project was jointly carried out by The University of Michigan School of Education and the City of Ann Arbor. The Project served a population of approximately 750 children and their families through day care centers and family day care homes in Washtenaw County. It developed a comprehensive and interdisciplinary approach to early health assessment and follow-through for children and for training and consultation for day care staffs on behalf of children and their families. The project's innovative approach explored adaptations of the Early and Periodic Screening, Diagnosis and Treatment model. This approach included making available a separate developmental assessment on-site for each child in the day care setting.

In addition to developmental assessments for children, interdisciplinary project teams, which included a nurse, social worker, and an education practitioner, provided systematic consultation and training to the children's caregivers, based on goals set with the day care staffs. This interdisciplinary team approach affected outreach, assessment of the "whole child's" health, follow-up, case monitoring, and technical assistance in two ways. It demonstrated a means of enhancing preventive health care for young children. In doing so, it emphasized the primary support day care centers could provide for families. In turn, this augmented the secondary support role of agencies by promoting coordination of local resources for families using day care. The long-range implication of these methods is to increase mutual helping between day care staff and families for the well-being of the children involved.

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Introduction

The City/University EPSDT Day Care Project has accomplished its major goal. It has demonstrated the use and benefits of coordinated, interdisciplinary teams to provide outreach, assessment of the "whole child's" health, follow-up, case monitoring, and technical assistance to caregivers. In so doing, it has demonstrated that a meaningful comprehensive child health assessment program can be implemented through day care. With the assistance of community practitioners, caregivers have been better able to address the special needs of children during the crucial developmental period from birth to five years, and have better met the needs of these children's families. The Day Care Project field-tested a program of day care support for continuity of comprehensive health care, a model which may be useful in future policy planning on a local, state, or federal basis. In addition, the model has demonstrated the practical value of enhancing linkages between day care and the wide variety of available community resources.

In this report, comprehensive is used in two senses. First, it is used in a linear sense to mean outreach, assessment, and follow-up, which includes case monitoring and long-term follow-through. Second, it is used in a more global sense to refer to a "whole-child" philosophy of health: health is seen as an interdependent relationship among physical, cognitive, social, emotional, and environmental aspects of the child's development.

Since the system developed by the project for comprehensive child health assessment through day care is consistent with the kind of assessment recommended in Developmental Review as expressed in the 1977 Final Report prepared by the American Association of Psychiatric Services for Children, we will also use two of their terms: assessment, to describe the process of our comprehensive health methods, and screening, to describe the medical assessment stage of our review of children's health.

The project's initial concern with health and with enhanced EPSDT services led us to explore broadening the health services available to young children and their families. In considering goals for a wider range of services, the project worked from three assumptions: first, that most health problems could be corrected or eased by providing children with broader health services; second, that children's health is an interrelation among physical, developmental, social-emotional, and environmental elements; and third, that if the project improved the overall health of children, both human stress and money spent on health care would be reduced in the long run.

Based on our assumptions and on our evaluation of services available, the project developed three major goals for improved health services: to provide clearly defined comprehensive health assessment for children; to expand health services available to the children assessed; and to link service providers so they could coordinate their assessment and follow-up procedures to reduce fragmentation and duplication in service delivery.

The project saw day care as a viable means of reaching these goals. In three years, a population of approximately 750 children and their families were served through day care centers and family day care homes in Washtenaw County. We developed methods to expand the role of day caregivers so they could provide for comprehensive health assessments for children in their care. We also provided services and training so caregivers could adequately follow up assessments with any needed services. This method demonstrated its benefits: it ensured that children received follow-up for problems identified during assessment and health care attention for problems which arose between assessments. It also provided a channel for coordinated outreach by community resources which allowed them to increase their preventive services for young children with little increase in cost. The approach also allowed agencies to return to a secondary support role for families, giving the primary support role to day caregivers--the people closest to the family in its daily activities.

Procedures and Instruments

Interdisciplinary Methods

The project developed teams composed of a nurse, a social worker, and an early childhood education practitioner. Each team of three specialists was aided by a team assistant who recorded and distributed team minutes, kept files up to date, did groundwork and research where necessary, and gave general assistance in assessing and preparing training activities. "Interdisciplinary" has several meanings, and the interdisciplinary element in the project's approach has evolved through several of them. The project began with separate disciplines working along side one another--something of a multidisciplinary approach. By the third year, the staff had been reorganized along more interdisciplinary lines.

The three team members worked together to integrate their areas of individual expertise. Each team member served as a generalist, not in the sense of an individual operating across disciplines, but rather as a specialist who could also take into account the resources and frames of reference of other disciplines. Each individual team member carried out training and follow-through activities, including contacts with community agencies, in her own discipline, and each team worked together so that all disciplines were represented in the content of workshops and in the follow-through decisions made.

This interdisciplinary approach was essential in two major project thrusts: programming and coordination. Programming dealt with the immediate delivery of day care services to the child and his or her family. In coordination efforts the child's relation to his or her whole environment (home/center/community) was of concern. Interdisciplinary programming in this area allowed us to, for example, have an increased awareness of the relationship of physical problems to social-emotional behavior concerns, and to have integrated skills and resources immediately available to remediate problem situations.

The second major use of the interdisciplinary approach was in interagency coordination. It allowed us to deliver services with qualitative efficiency and to effectively utilize the specialized skills of providers from various agencies.

The physical proximity of the interdisciplinary team members, being housed together in the same office, probably had a considerable effect on the coordination of the disciplines. Informal, everday contacts reinforced the team's more formal meetings and increased communication. It is less likely that this sort of proximity would be

immediately available to community agencies adopting the project's approach, but its effect should be kept in mind, and similar or alternative means of increasing interdisciplinary communication should be considered.

Project Activities

Project activities can be broken into two major phases. Each of these phases can be further broken down into the stages in which the project's interdisciplinary methods and instruments were implemented. The conceptual framework for the project's goals and procedures are diagrammed in Figure 1.

Phase I: The Comprehensive Health Assessment Process (see Figure 2):

Stage 1: Parents fill out the Health and Developmental History Intake Form and discuss it with a day care staff person. The form is one developed by the project and adapted by each center to meet its needs (available in the Health Training Modules).

Stage 2: Medical screening is provided for the children. (For optimal and efficient participation, the project recommends this be done on-site.) This includes the EPSDT protocol and dental screening (or a modified screen in accordance with particular needs of a specific community).

Stage 3: A comprehensive developmental assessment is administered on-site by day care staff and practitioners working together, for each child whose parent has given permission. The Developmental Indicators for the Assessment of Learning (DIAL) was the assessment instrument used in this stage.

Stage 4: Feedback sessions are held between day care staff and project staff to integrate the information obtained from the health assessment process and from observations. Remediation plans are made for groups of children and for individual children for whom there is concern.

Stage 5: Follow-up takes the form of communication with parents, individual referral, monitoring of referrals, training, consultation, health and safety policies, and records (see model Health Policy in Health Training Modules).

Phase II: Technical Assistance--
Consultation and Training (see Figure 3):

Stage 1: The comprehensive health assessment process of Phase I continues. There is continued observation for children with special needs; the intake form is provided to newly enrolling parents; there is continued monitoring of referrals and program plans; health and developmental assessments continue to be available.

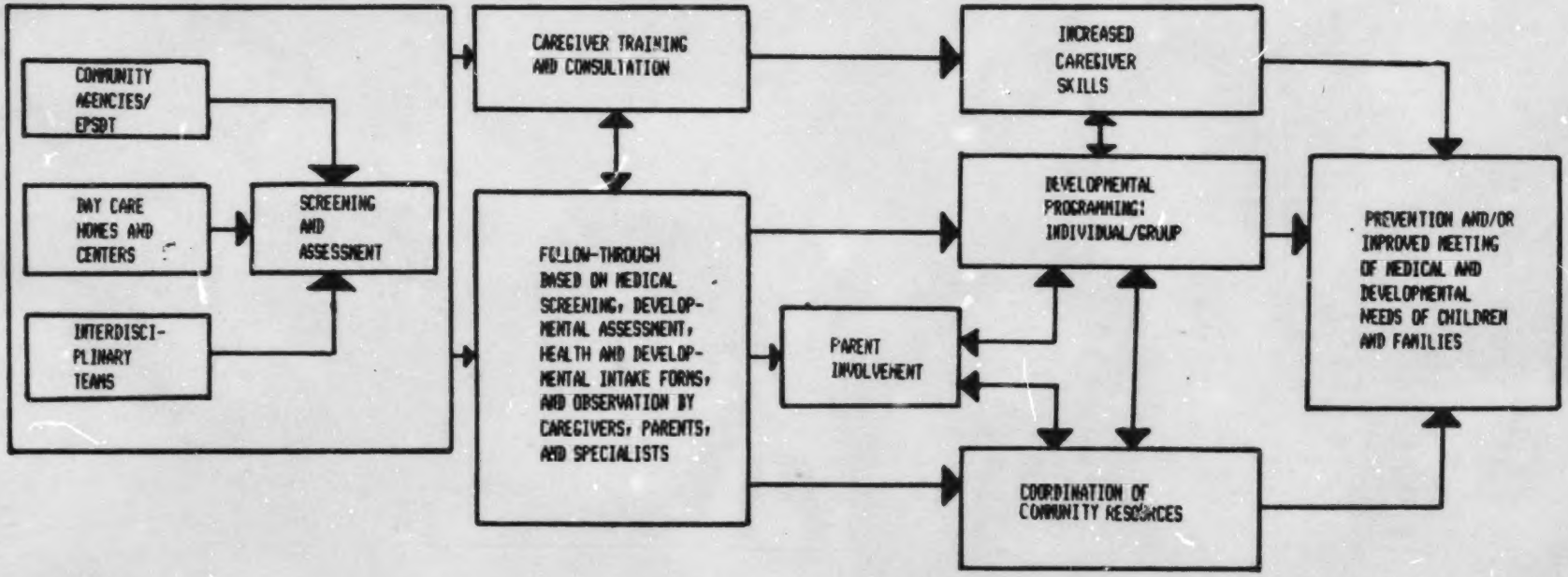
Stage 2: The Caregiver Questionnaire is provided to caregivers, directors, and practitioners to assess needs for training and consultation. The questionnaire is a comprehensive instrument developed by the project's interdisciplinary staff with the assistance of the evaluation team. (See Figure 4 for the conceptualization of the needs assessment. See Figure 5 for a sample page of the questionnaire.)

Stage 3: Mutual goal-setting sessions are held between project staff members and day care staffs during which information from the health assessments, the caregiver questionnaire, project staff observations, and caregiver ideas about their training needs are integrated. Goals are agreed upon and training and consultation plans are made for implementing the goals. Goal-setting sessions can be held periodically to reassess previously set goals and accomplishments, and to reset goals when necessary.

Stage 4: Interdisciplinary consultation and training sessions are provided at central locations for basic and common topics, and on-site at day care centers or in day care homes to meet individual goals. (Training materials developed by the project are in the modules on health, social-emotional needs, and curriculum.)

Stage 5: Continuous observation and follow-up for individual children for whom there is concern and consultation with day care staff provide follow-through and implementation of plans for children and day care staff. This is an ongoing means of case management support for day care staff.

FIGURE 1: CONCEPTUAL FRAMEWORK FOR INTERVENTION STRATEGY


COMMUNITY AGENCIES/ EPSDT
DAY CARE HOMES AND CENTERS
INTERDISCI-PLINARY TEAMS
SCREENING AND ASSESSMENT
CAREGIVER TRAINING AND CONSULTATION
FOLLOW-THROUGH BASED ON MEDICAL SCREENING, DEVELOP-MENTAL ASSESSMENT, HEALTH AND DEVELOP-MENTAL INTAKE FORMS, AND OBSERVATION BY CAREGIVERS, PARENTS, AND SPECIALISTS
PARENT INVOLVEMENT
INCREASED CAREGIVER SKILLS
DEVELOPMENTAL PROGRAMMING: INDIVIDUAL/GROUP
COORDINATION OF COMMUNITY RESOURCES
PREVENTION AND/OR IMPROVED MEETING OF MEDICAL AND DEVELOPMENTAL NEEDS OF CHILDREN AND FAMILIES

I. INPUT

II. PROCESS (ENABLING GOALS)

III. OUTCOME

(ULTIMATE GOALS)

11

12

IV. DEMONSTRATION GOALS

FIGURE 2: FOLLOW-THROUGH PROCEDURE

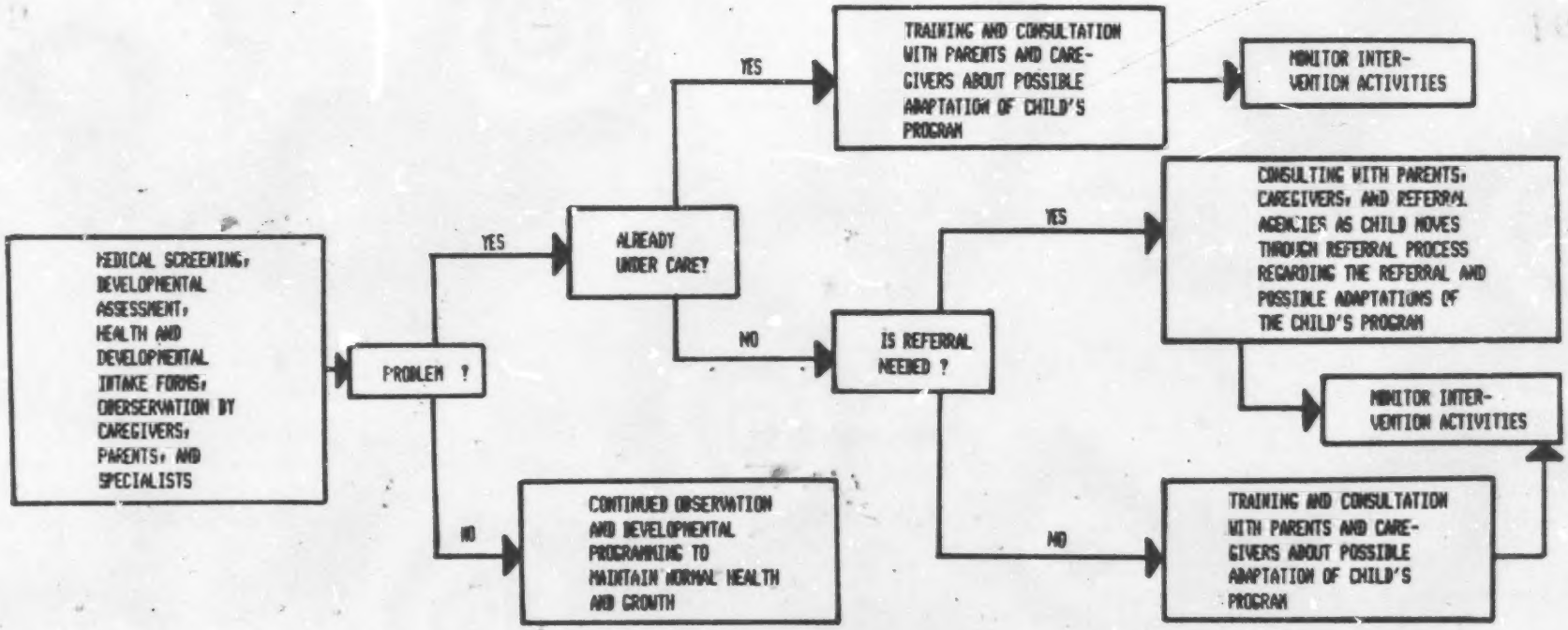

MEDICAL SCREENING, DEVELOPMENTAL ASSESSMENT, HEALTH AND DEVELOPMENTAL INTAKE FORMS; OBERSERVATION BY CAREGIVERS, PARENTS, AND SPECIALISTS
PROBLEM ?
YES
ALREADY UNDER CARE?
YES
TRAINING AND CONSULTATION WITH PARENTS AND CARE-GIVERS ABOUT POSSIBLE ADAPTATION OF CHILD'S PROGRAM
MONITOR INTER-VENTION ACTIVITIES
NO
IS REFERRAL NEEDED ?
YES
CONSULTING WITH PARENTS, CAREGIVERS, AND REFERRAL AGENCIES AS CHILD MOVES THROUGH REFERRAL PROCESS REGARDING THE REFERRAL AND POSSIBLE ADAPTATIONS OF THE CHILD'S PROGRAM
MONITOR INTER-VENTION ACTIVITIES
NO
CONTINUED OBSERVATION AND DEVELOPMENTAL PROGRAMMING TO MAINTAIN NORMAL HEALTH AND GROWTH
NO
TRAINING AND CONSULTATION WITH PARENTS AND CARE-GIVERS ABOUT POSSIBLE ADAPTATION OF CHILD'S PROGRAM

FIGURE 3: CAREGIVER TRAINING AND CONSULTATION

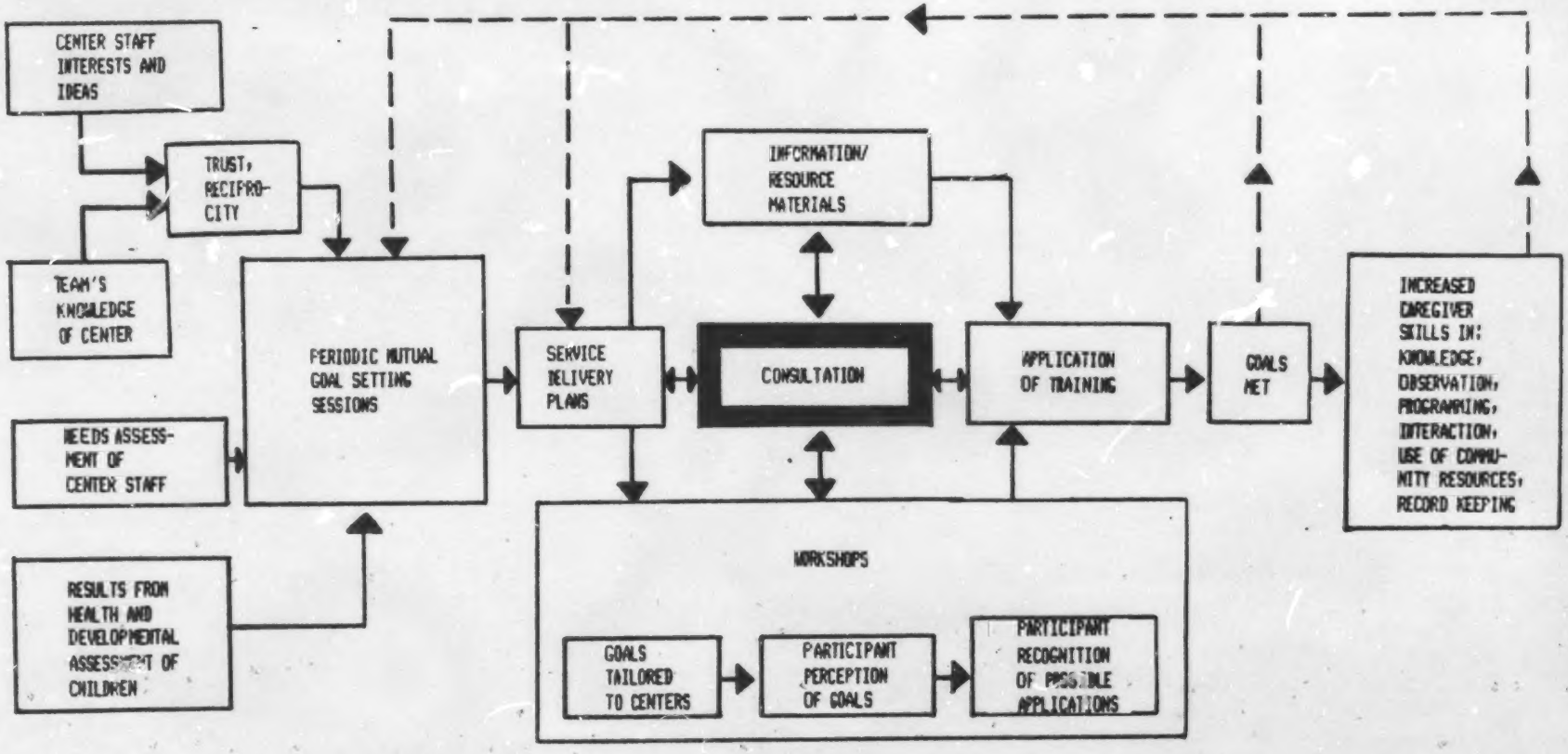

CENTER STAFF INTERESTS AND IDEAS
TRUST, RECIPRO-CITY
TEAM'S KNOWLEDGE OF CENTER
NEEDS ASSESS-MENT OF CENTER STAFF
RESULTS FROM HEALTH AND DEVELOPMENTAL ASSESSMENT OF CHILDREN
PERIODIC MUTUAL GOAL SETTING SESSIONS
SERVICE DELIVERY PLANS
INFORMATION/ RESOURCE MATERIALS
CONSULTATION
APPLICATION OF TRAINING
GOALS MET
INCREASED CAREGIVER SKILLS IN: KNOWLEDGE, OBSERVATION, PROGRAMMING, INTERACTION, USE OF COMMU-NITY RESOURCES, RECORD KEEPING
WORKSHOPS
GOALS TAILORED TO CENTERS
PARTICIPANT PERCEPTION OF GOALS
PARTICIPANT RECOGNITION OF POSSIBLE APPLICATIONS

FIGURE 4: ITEM CONTENT MATRIX FOR CAREGIVER QUESTIONNAIRE/CENTER NEEDS ASSESSMENT

TOPICS FOR CAREGIVER TRAINING

DESIRED CAREGIVER SKILLS	HEALTH	SAFETY	NUTRITION	DEVELOPMENTAL SKILLS: GROSS MOTOR	DEVELOPMENTAL SKILLS: FINE MOTOR	DEVELOPMENTAL SKILLS: CONCEPTS	DEVELOPMENTAL SKILLS: COMMUNICATION	SOCIAL/EMOTIONAL DEVELOPMENT	PARENT INVOLVEMENT	STAFF INTERACTION
1. KNOWLEDGE (Basic information needed prior to application)										
2. OBSERVATION (Recognizing, detecting, assessing, diagnosing specific behaviors or problems)										
3. PROGRAM PLANNING (Matching activities to abilities, using materials appropriately, organizing ideas for program implementation)										
4. INTERACTION (Building rapport or relationship, modeling, managing, presenting, implementing planned activities)										
5. USE OF COMMUNITY RESOURCES (Finding resources appropriate to needs, facilitating family contacts with community agencies)										
6. RECORD KEEPING (Developing and/or maintaining a record-keeping system to chart progress or changes, using records in planning)										

FIGURE 5: SAMPLE PAGE FROM THE CAREGIVER QUESTIONAIRE/CENTER NEEDS ASSESSMENT

NUTRITION	Current Skill Level: Unfamiliar with this area (1)	Have begun to develop skill in this area (2)	Have acquired a fair amount of skill in this area (3)	Am quite skilled in this area (4)	Importance: Not important (1)	Somewhat important (2)	Important (3)	Essential (4)	Effectiveness of Project: Ineffective (1)	Somewhat effective (2)	Moderately effective (3)	Very effective (4)	Would you like help from the Project in this area? Yes (Y)	No (N)
C1. Knowing the developmental food habits of preschool children and what is needed for a well-balanced diet.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
C2. Being aware of problems in an individual child's eating habits.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
C3. Utilizing nutritious foods in daily programming (e.g. snacks, stories, arts, teaching concepts).	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
C4. Helping children develop a positive attitude toward eating nutritious food.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
C5. Obtaining free or inexpensive information and consultation regarding planning meals and snacks that are nutritious and appealing.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N
C6. Keeping track of the kinds of food served for lunches or snacks.	1	2	3	4	1	2	3	4	1	2	3	4	Y	N

Summary of Activities and Findings

Medical and Dental Screenings

Different approaches to providing medical screening were taken each of the three project years. The first-year screening was done on-site. The second-year screening was provided at the health department's county service center, with the project providing transportation. In the third year, families provided their own transportation to the county service center where screening was held. The proportions of children screened were approximately the same the first two years (39% and 44%), while in the third year the proportion dropped considerably (16%). This drop reflected the inconvenience of the time when screenings could be scheduled (during parents' working hours) and the difficulty of getting to the county service center for screening. Also, there were many children who had been screened the previous year whose parents did not choose to participate a second time, and there was one new center the third year which did not participate in the screening program at all.

In the third year an on-site dental screening was also arranged by the project. Thirty-seven percent of the children in the project received this screening.

The number of children who were found in the medical screening to have referrable problems was lower than in the general EPSDT population, age 0 to 5, perhaps because the project served more middle class children than the normal EPSDT population. In 1978 in the U. S., 55% of the children aged 0 to 5 given the medical screening had referrable conditions. In Washtenaw County, 33% of the children screened in this year had referrable problems. The project, during its three years of screening, found, respectively, 20%, 25%, and 19% of the children screened to have referrable problems. For the combined referrals made by the health department and the EPSDT clinic, referrals for hearing problems were most common.

Project records showed that children in our population for the most part did not see a physician regularly on a preventive basis. Visits to doctors were crisis-oriented. This was most likely to be true for families on the borderline of medicaid eligibility. The large proportion of non-medicaid eligible families who took advantage of the project's screening resources suggests the need felt by these families for preventive care.

Dental care on a regular basis was almost non-existent for children in the project population. About 39% of the children screened were referred for dental problems after we

had arranged for a mobile dental screening unit to examine children at their day care centers.

It is the conclusion of the project medical staff that if medical screening were to be universally available to children in day care, a modified screening which included only hearing, vision, dental, and developmental assessment might be sufficient. Further testing could be available when particular environmental or genetic conditions exist (e.g., lead-level testing for those in old housing, sickle cell tests for black children).

For centers wishing to establish a dental screening and follow-up program, a health consultant who provides information and demonstration tools for dental screening, and a dentist or dental hygienist to do the actual screening, would be essential. A public health nurse, dental assistant, or dental hygiene student from a local community college or university might be used for teaching and dental screen preparation.

Developmental Assessment

The DIAL was used by the project to point up gross deviation from normal development. It was used to help observers pinpoint areas of children's difficulty. It was also useful as a teaching device to make caregivers more aware of stages of child development, as a planning tool for group developmental activities, and as a rescreening device where the need for referral was unclear. Finally, using the DIAL in preschool gave the parent of a child with problems additional time to come to terms with a troubling life situation. Many parents needed time and notification from several sources before accepting the fact that help might be needed for their child. The early DIAL screening aided this process. The number and type of developmental problems found using the DIAL, for each of the three project years, are summarized in Appendix 1.

Developmental screening for the day care population in Washtenaw County may be continued by the 4C's organization, Child Care Coordinating and Referral Service, following project termination. This agency is setting up a Consultation Referral Service with consultants from community agencies who have been trained by project staff to administer the DIAL. They, in turn, will train caregivers from interested centers to give the DIAL under their supervision. If necessary, DIAL administration can be limited to those children about whose development the parent or caregivers have a question, thus reducing the screened population to a size that is manageable and one which could be followed up by caregivers and a small group of consultants.

Problems in Referral

When the project first approached screening, a major goal was to locate handicapped preschoolers and to make certain they received adequate diagnostic testing and subsequent treatment as provided by the Federal 9401 legislation and PA 196. Actually the project uncovered few such children, and most of those we found had already been identified. However, the project followed these children to make certain they received the services to which they were entitled, and in the process became aware of certain shortcomings in the agencies serving the preschool handicapped. Often the agencies were guilty of non-compliance with the law which requires action within 39 school days of referral. Except in extreme cases, the school systems did not provide and were unwilling to pay a day care center for consultation about rehabilitative services. (Some consultants were sent to the centers to provide or advise on programs for speech problems.)

Although the project located few handicapped children, by working with the caregivers we uncovered a number of minor developmental problems. For example, children with slow speech or language, or other inadequate communication skills, which would not qualify them for services under the handicapped law, were found. Left untreated, by age six or seven they might become special needs children. Caregivers needed help with these children, help which the project's interdisciplinary team of consultants could usually provide. Unfortunately, when the project terminated no public agency assumed this responsibility.

Case-management

For the handicapped child and for the child with minor problems, the project's interdisciplinary teams played the role of case manager. The teams followed the child through screenings, diagnosis, if indicated, and subsequent treatment. They helped the staff plan programs and observed the child's progress. They also helped staff reach parents, many of whom were reluctant to face the possibility of their child having problems. At the end of the project, the director of a day care center might become the case manager if she or he had supportive consultation. This would be especially important where she was dealing with a denying or abusing parent. With this support, the director would be in a good position to take case-management action and follow it through. Partly as a result of the project's activities, local community agencies have begun to look at day care facilities as a real resource, and centers have more knowledge of community agencies, thus further easing the director's potential role as case manager.

Record-keeping

Project findings paralleled those of the 1974 Ann Arbor City Day Care Study on the state of day care center records. Records, and especially health records, were scattered, in poor condition, and not easily available. To counteract this problem, the project provided every center with a health policy prototype which outlined necessary health records. Something similar to this will soon be required by the state. (This prototype is available in the Health Modules of the training materials.) Currently all of the project centers have improved their record-keeping systems and many have adopted the project intake form which combines medical and developmental information.

Health and Safety

Health and safety was a topic on which the project succeeded considerably in raising consciousness. Some caregivers said this was the best contribution of the project. Changes in this area were often basic, often simple. Several centers were helped to put first aid kits together for the first time. In one center, the sheet for listing administration of children's medications was far from the refrigerator where the drugs were usually administered, so signing was erratic. A project suggestion to move the sheet was adopted and greatly improved the record-keeping.

Project nurses were quickly available for medical crises, like lice or a child stuffing something up her nose. The project staff responded and left behind some written factual material so that a reasonable medical protocol would be available for the next similar crisis. Each center was also given a ring binder of cards that pictured and described the symptoms and treatment of common illness or infestation. Finally, since a recent audit by DHEW showed many Michigan centers to have health and safety violations, the project developed safety check lists for each season to facilitate proper safety measures (available in the Health Training Modules).

Parent Involvement

From its inception, the project objectives stressed parental involvement, and efforts were made to involve parents in all phases of project activity. The project required parents' knowledge and permission for all procedures involving their children. Information about the results of all screenings were sent, or given directly, to parents. In addition, parent involvement was both a hidden and an open agenda item in the project's training effort. In all of our training and consultation we stressed the importance of eliciting all information about a child from

his or her parents and the necessity of planning and problem-solving with parents. Parent involvement was an explicit goal for all of the centers involved in goal-setting; it was also an implicit goal in most, if not all, of the training in the other goal areas.

While several centers made significant changes in working with parents based on project recommendations, for the most part project staff felt there was little real movement toward increased parental involvement in most of the centers. The fact that all centers adopted parent involvement as a goal indicates some recognition of the need for increased parent involvement (project staff lobbied for the goal prior to mutual goal-setting, however), and all centers, of course, already had some form of regular contacts with parents. Unfortunately, like any of the interpersonal relations areas, parent involvement was an elusive training area and a difficult one in which to put specific program activities into effect. Because of the difficulties both in training and in measuring change in this area, for many of the centers parent involvement goals were only partially met.

One important project product was aimed at Parents. This is the Parent Activity booklet, Big Hands, Little Hands Together. It was sent out to each parent along with the results of the developmental assessment. The booklet gives many examples of specific children's activities that foster development in the four areas of the DIAL--gross motor, fine motor, concepts, and communication--and that can go on at home.

Training and Consultation

The technical assistance phase of the project included both immediate and long-term follow-through and prevention activities. Follow-through activities ensured long-term case monitoring for children with special needs as identified by the formal health, developmental, or dental assessments, or by more informal observations by parents, caregivers, or project staff. Case monitoring was done primarily through ongoing consultation on children who had referrable and nonreferrable medical or developmental problems. Prevention activities included increasing caregiver knowledge and skills in observation; programming, including record-keeping; working with parents, possibly preventing problems for all children in a family; and training for caregivers in child development. This last was particularly important because the more caregivers knew about development, the better able they were to plan appropriate activities and to know when children had problems in development.

Among the most salient aspects of the project's follow-through approach was its capacity to deal with problems which had not reached the referral stage. Project teams were able to alert centers to the implications of conditions indicated on the Health and Developmental Intake Forms which might affect children's behavior or welfare while in the center. Further, they were able to provide information to the centers about program adjustments or support for children with problems already under care. Because the project was interdisciplinary, the team could assess problems from a variety of angles--the developmental and social/emotional implications of a hearing problem, for example.

Caregivers played an important role in prevention. Since they could observe children on a day-to-day basis, they could provide information useful for interpreting the validity of the results of the developmental assessments. The project teams worked with center staffs to provide supportive, preventive programs, both in the short run for specific children with identified problems, and in the long run by providing training for staff members. The on-site accessibility of the project teams also allowed them to respond to a number of informal requests from caregivers or parents for preventive consultation or information.

The project's follow-through efforts were important when referrable problems were discovered. The project teams followed most referred problems beyond the initial appointment, which is in most cases the stopping point for the traditional EPSDT follow-up process. For intensive follow-through efforts, the teams were able to provide continuity by following the remediation process as it moved among several community service agencies. The value of the project's follow-through approach may be most apparent for developmental problems, where problem identification typically is not clear-cut and where services are often difficult to obtain. Working with caregivers and parents, the teams helped to build preventive center programs for low-level problems, and, where referrals were needed, they were able to help parents and children obtain the services necessary.

The table in Appendix 2 provides a thorough review of the technical assistance offered by the project to increase caregiver skills in prevention and follow-through on behalf of the young children in their care. In the process of providing this technical assistance, the project developed a number of useful methods and instruments, and these are described below.

Establishing Relationships with Centers:

The foundation for consultation and training was the relationship between the project and the center staff. It was the critical factor in determining a center's willingness to utilize the information and approaches the project offered.

There were several ways in which this relationship was fostered. The first was the use of a project team coordinator or liason to each center. This person attempted to establish herself almost as part of the center by visiting frequently and often working with the children. She could provide a model for desired behavior and lessen the distance to herself as "the professional." Once trusted, she could establish the credibility of the rest of the team.

The project's attitude toward the center was also critical in forming a good relationship, and was based on a non-judgemental attitude of respect, particularly toward the center's autonomy, style, knowledge base, and philosophy. A formal agreement preceded any work with a center. Project staff also tried to be sensitive to the concerns of the center--responding to needs when the center staff themselves recognized those needs and were ready to work on them. Ideally, the project tried to maintain the authoritativeness and perspective of an outsider combined with an insider's understanding of the individual setting.

Final aids to relationship building were the on-site visits of the project team. First it was necessary for each team to start the process of building internal trust and consensus. Then the entire team went to the center to administer the DIAL and later to give feedback on it. All were usually present at the on-site workshops. This provided a good opportunity for project and center staff to become acquainted and to develop the reciprocal, open, working relationships necessary for concentrated training and consultation activities.

Needs Assessment and the Caregiver Questionnaire:

In the first and second year several approaches were tried, but it was not until the third year that the project teams were able to develop a comfortable and productive way to assess a center's training needs. The teams did not want just to observe and pass judgement on a center, but rather wanted to find a systematic way for centers to have input into an assessment of their needs. Consequently the Caregiver Questionnaire was developed. The questionnaire had two advantages: it provided a systematic means for center staff to assess their own needs, and, in the process, served as a self-educating tool. The topical headings in

the questionnaire were Health, Safety, Nutrition, Gross Motor, Fine Motor, Concepts, Communication, Social-emotional, Parent Involvement, and Staff Interaction.

The questionnaire was completed by each caregiver, and a slightly modified version of the same questionnaire was filled out by the center's director and by the project team. When all questionnaires for each center were compiled they provided a profile of assessed needs for that center.

Mutual Goal-setting:

Once the screening phase of activities was completed and the Caregiver Questionnaire was filled out, the project needed a way to transform this information into goals for effective and individualized consultation and training for each day care setting. Again, it was in the third year that these mutual goal-setting sessions were systematized.

Mutual goal-setting sessions used information from the DIAL group profiles, relevant health screening results, the center's needs assessment profile put together from the questionnaires, team and center staff observations, and center priorities. This information, along with the center staff's current ideas, was synthesized, and from it goals and priorities for the next six months of consultation and training activities were determined.

The great variation in the goals set by the different centers speaks to the flexibility and responsiveness the team maintained during goal-setting and follow-up. The result was a highly individualized approach to training and consultation.

Workshops:

By the third year of project activities, training methods were developed that were responsive to individual center's needs. The project approach encouraged more center initiation in training, more mutuality in defining and achieving goals, and more informal consultation than had been possible in previous years.

The project used both individualized, on-site training on topics generated by the mutual goal-setting sessions, and central, "core knowledge" workshops. These proved to be highly effective both in training new day care staff in fundamentals and in meeting the specific needs of each center. In total, the project provided fifty-three workshops on twenty-eight different topics during the third year. During the project's three years of training activities, centers asked that training move from an initial concentration on the major curriculum areas of the DIAL to

more emphasis on social-emotional and health and safety issues.

In general, the project's workshops were developed to take into account participants' interests and needs; the logistics of time, available space, and group size; continuity between workshops; and ways to encourage maximum participation. The workshop format was generally a formal presentation with time for questions, combined with participatory and experiential methods like caregiver participation in activities for children; problem-solving; role-playing; "make-it-and-take-it"; and support techniques such as films, displays, and hand-outs.

Consultation:

The project found that for greatest impact, the consultant had to vary her role to meet the demands of the situation encountered. Project staff used a continuum of consultant roles, from least to most directive, as described by Gordon and Ronald Lippet in, The Consulting Process in Action. These roles consist of: the objective observer/ reflector; process counselor; fact finder; joint problem solver; trainer/educator; information specialist; and advocate.

The project offered consultation to serve six major functions. A great deal of consultation occurred as follow-up to developmental assessment. Teams met with center staff, parents, and personnel from other agencies to discuss results and to recommend action. Health consultation included follow-up of the "Common Illnesses" workshops and of health screening. This was most often referral to an eye doctor or an orthopedist, but other consultation was done. Consultation in social-emotional areas was woven into almost all discussions concerning children. Often the team dealt with concerns about aggression, separation, withdrawal, and toileting. Many project consultations occurred around curriculum and program planning with both directors and staff members. This included aiding centers in the orientation and training of new and inexperienced staff.

Parent involvement was yet another area for consultation. Centers seemed to have no one definition of parent involvement, and consultation involved anything from informing centers about a special parent-interview video tape being done by the Child Care Coordinating and Referral Service, to providing suggestions and materials for a Make-It-and-Take-It workshop organized for parents by the center. With every opportunity, project staff tried to promote a better understanding and a closer working relationship between center staff and parents.

A final area of consultation was in staff relations. One center requested special assistance with staff communication skills, and the topic was the focus of several workshops held for center directors.

Follow-up for Technical Assistance:

A lot of information was delivered in a short time during project workshops. To enhance the effect and relevance of the material presented, it was important to reinforce it after the workshop was over. This was done through various hand-outs; carrying through with requests for follow-up expressed by caregivers on their workshop evaluation forms; giving encouragement to reinforce any changes made in response to a workshop; and providing consultation to meet requests which arose at the workshops.

Group meetings with center directors were also held to explore ways to reinforce and follow-through on screening, consultation, and training activities with their staffs. The meetings provided support for the directors and reinforced the training and consultation occurring in their centers. The sessions also increased the directors' use of consultation resources from the project and from the community to help them meet their roles and responsibilities.

The project determined, after the third year, that holding periodic mutual goal-setting sessions would further improve the project model. More frequent sessions would allow day care staff to reassess, clarify, and amend their goals as the year progressed.

The technical assistance provided by the project resulted in the development of training materials which have been published to share the content of workshops and to suggest methods for utilizing them. The materials consist of a series of three books: "Teacher, I Don't Feel Well:" Meeting Children's Health Needs, which includes modules in the areas of First Aid and Common Childhood Illnesses, as well as a model health policy for day care centers; "Feeling Good:" Helping Children Grow Emotionally and Socially; and "What Do We Do Today?": Planning a Developmental Curriculum.

The training materials are designed to be presented in workshop format, by trainers, to an audience of caregivers of young children. The materials are also appropriate for self-instruction, Child Development Associate Training, and courses at the high school, junior college, or university level.

Each workshop module includes everything a trainer needs to present the program: training objectives, factual

material, suggestions for presenting the material, resource articles, follow-up ideas and hand-outs which may be reproduced for participants. Pages designed for and used by the project as handouts are marked with the project title.

It is recommended that these training materials be used within the context of mutual goal-setting, ongoing availability of consultation for follow-through support, and evaluation of the effectiveness of the technical assistance by the methods identified below.

Evaluation for Technical Assistance:

The project had three methods for evaluating workshops and consultations:

1) Evaluation forms were filled out by caregivers after each workshop to assess the extent to which specific workshop objectives were met (forms are available in final report);

2) Following training sessions, project staff conducted their own self-evaluation, which incorporated caregivers' comments from the evaluation forms;

3) The project periodically assessed the overall goal-attainment of each center which resulted from consultation and training activities, and it assessed the value of its longer-term assumptions about the interrelationship of health assessment, consultation, and training, the value of the interdisciplinary approach, and the impact of increased caregiver skills on prevention.

The time needed to validate the effect of training on permanent change and growth of skills was greater than the duration of the project allowed. However, small but consistent gains were measurable. Linkages were found between needs assessment, goal-setting, training delivery, and training application, which indicate that progress toward center goals was indeed made.

Changes in the pre-post caregiver group skill self-rating were consistently positive, although in only a few areas statistically significant. The most positive changes were in the health and safety areas and in the use of community resources across all the areas.

Evaluation also indicated that where consultation was used to facilitate and reinforce the application of training, the effectiveness of the training was likely to be greater. Thus, consultation played a central role in facilitating the application of training and in the meeting

of goals. As ideas were used and goal attainment was assessed, the information was recycled back to mutual goal-setting and/or service delivery planning. This recycling was particularly important given the high staff turnover rates in day care--needs had to be continuously reassessed as new staff moved in.

Family Day Care

As with day care centers, the extent to which project goals could be met with family day care (FDC) depended on the relationship, trust, and rapport between the FDC consultant and the FDC-giver. But the nature of the FDC setting altered the ease with which this relationship could be forged. The FDC center is smaller, home-based, and more isolated from the flux of happenings than the larger center. This is the great advantage of these homes, and FDC-givers are protective of the privacy and degree to which outside influences affect their environment. While these conditions offer many benefits for children, they also made it more difficult for the project to establish the communication and trust necessary to assist these homes to make optimal use of community health services and resources. This difficulty was compounded by the fact that the center program was a very ambitious one, and drew virtually all the time and staff available to the project during its three-year tenure. Creating a completely different program for FDC was beyond our resources, yet family day care homes had different needs than centers. For example, it was difficult and sometimes undesirable for FDC-givers to acquire a substitute to look after the FDC children while they attended a workshop at a center. Consequently, the program for FDC was very different from the program for the centers.

The project tried several approaches. In the first two years of the project, family day care assignments were added on to center assignments, with many staff members having one or more homes to work with. In the last year, the staff member who had most interest in and rapport with family day caregivers was assigned to work with all FDC homes (in addition to working with one center). With the help of one evaluation specialist and the back-up of an interdisciplinary team, this coordinator worked out a more consistent approach to working with family day care, including assessing FDC needs, establishing informal goals, and providing bi-weekly consultant services. By the end of the third year, a link had also begun to be established between some family day care homes and one center.

In all, FDC-givers required a longer period for building relationships with the the project than did center staffs and called for a more individualized approach, including home visits, for service delivery. By the end of the third year, the project had not developed as complete a

model for work with homes as for work with centers, but had begun to establish the network links it desired between homes and the project. Generally, the project developed individualized and varied approaches to use with FDC-givers.

Service Coordination Efforts and Their Impact

Our first-year goal of having agencies deliver services directly to the centers helped by project coordination was overly ambitious--agencies simply were not willing to so completely alter their delivery methods. Realizing this, in the second and third years the project turned to a broader, two-pronged approach to service delivery. The project developed innovative methods for service delivery, provided some services itself, and contracted with agencies for other direct services as needed.

We began by becoming well informed about, and familiar and experienced with, the human service resources in the community. From this base we worked to develop relationships and communication between line staff at the various agencies.

Eventually three channels were developed to facilitate this process. First was the advisory committee to the project. This committee was widely representative of agency resources in the community and provided visibility for resource providers. Second, during the second project year the local Community Coordinated Child Care (4-C's) affiliate, Child Care Coordinating and Referral Service (CCCRS), began to hold meetings to consider organizing a resources consultation network. This initially resulted in a committee of interagency staff members, supported by their respective agency directors, which published short- and long-term recommendations for increasing coordination of services among Washtenaw County agencies. These first two efforts generated a third opportunity for agency resources to get together: the intermediate school district representative, who attended both meetings, began to host luncheon discussions where resource people described to one another the services, and the regulations affecting those services, available through their agencies.

As a result of project efforts, day care directors were able to use more resources and to use them in a more selective and consistent manner because agency services were made clear and because less overlap in their services existed. As centers came to value this, they too helped agencies coordinate services by requesting various kinds of collaborative services.

Project staff also assisted CCCRS in developing and disseminating a Washtenaw County resource guide for children

and their parents, "The Children's Yellow Pages," which further boosted agency use.

A major result of early project advisory committee and CCCRS consultant meetings was the Consultation Referral Service coordinated by CCCRS. This is an interagency network of consultants organized to enhance the quality, availability, and delivery of consultation services to caregivers of children from birth to five years.

Another major coordination effort was begun in the third year of the project. A staffing agreement was reached between CMH, CCCRS, and the project, whereby two half-time staff members from the same CMH team worked half-time with CCCRS and the project respectively. This fulfilled an original project goal of involving community agency staff directly with the project as a means of expanding use of the project's methods of service delivery. The CMH person attached to the project became the social work member of one team and served several centers. She found the team experience very salutary and is trying to continue some form of it in post-project CMH service to the day care community. This interest and support from CMH greatly aided the growth of coordinated services in the community and also helped the spread and adaptation of the project's interdisciplinary methods and materials.

The project made a final coordination effort with centers and agencies to promote continued use and adaptation of the project's methods and materials. As part of this coordination effort, in the early fall of the third project year, two persons from each agency (CMH, WPH, ISD, and CCCRS) were trained in the use of the DIAL. These staff are now part of the Consultation Referral Service coordinated by CCCRS. CCCRS will use the project's interdisciplinary training materials to provide training and referral to day care centers and public agencies serving young children and their families and will coordinate adaptation of project methods and materials for community use in the future.

The project's coordination efforts affected the community in three ways. The project strengthened community coordination of resources for young children and their families; enhanced the reciprocal awareness and use of the community's institutional resources and day care centers; and in the process, developed innovative methods and materials that day care and resource providers could use.

On a state and national level the project's methods and materials are timely and have potential for future use. In Michigan, the Interagency Committee for Services to High Risk Children and their Families is planning to increase interagency screening, some in the day care population. Title XX funds have been appropriated in the Michigan

legislature to begin a large training effort of day caregivers, and some of the project's principles, methods, and materials will certainly be used. On a national level, the new Federal Interagency Day Care Regulations mandate training of caregivers, and the project materials on health have already been cited as directly on target for this kind of training. Also in the federal sphere is the future enactment and implementation of the Child Health Assessment Program (CHAP). The project's methods and materials can be a valuable resource for the design and implementation of a child health policy as it relates to the children in day care and the community's agency linkages to the day care facilities.

Conclusions and Recommendations

CONCLUSIONS	RECOMMENDATIONS
We conclude that:	We recommend that:
1) Making comprehensive[1] health assessment available on-site at day care centers is an effective avenue for reaching children in need, and for involving center staff and parents in securing follow-through.	1) A comprehensive health assessment procedure be provided in day care facilities and be adapted according to each community's specific needs. For example, for Washtenaw County it is recommended that hearing, vision, dental, and developmental assessments be routinely provided.
2) The DIAL is a more effective developmental assessment for identifying children with potential problems than the Denver if consultants are available for interpretation and follow-through.	2) To find and assist children with potential developmental problems, the DIAL can be used if appropriate consultation for interpretation and follow-through is available.
3) An on-site dental screen, headed by a dentist, is more effective than the conventional EPSDT procedure of referring for dental care.	3) An on-site dental screen, done by a dentist, be conducted at day care facilities.

[1]Comprehensive has two meanings in this report. It refers to: 1) Methods, including outreach, assessment, and follow-up which include case monitoring and long-term follow-through; 2) A "whole child" philosophy of health: health is seen as an interdependent relationship between physical, cognitive, social, emotional, and environmental aspects of the child's development.

Conclusions and Recommendations (continued)

	CONCLUSIONS		RECOMMENDATIONS
	We conclude that:		We recommend that:
4)	The project's approach to assessment and follow-through by interdisciplinary teams is of particular value for identifying and assisting children with nonreferrable problems.	4)	To find and assist children with problems that are not serious enough now for referral but deserve attention so as to prevent future problems, assessment and ongoing consultation which incorporates parent and caregiver input be provided.
5)	The project's comprehensive and interdisciplinary approach provides for continuity in the follow-through process for referrable problems.	5)	On-site assessments, incorporating parent and caregiver input, be provided with ongoing coordinated interdisciplinary consultative support for day care staff and parents to secure follow-through for children with referrable problems.
6)	The project's interdisciplinary and consultative approach to assessing the "whole child's" development also provides a means for reviewing social-emotional needs.	6)	Day care consultants should use the persons who are closest to the child (i.e., parent and caregiver) to assist in assessment of social-emotional problems and for referral and/or remediation.

Conclusions and Recommendations (continued)

CONCLUSIONS	RECOMMENDATIONS
We conclude that:	We recommend that:
7) Carefully selected workshops based on need do not in themselves provide the necessary education for improving caregiver skills in working with children. However, if on-site consultation is interwoven with workshops, learning is reinforced and an increased utilization of training results.	7) A combination of training and consultation approaches be integrated for most effective caregiver training to meet the needs of children and their families.
8) Increased day care center use of community resources increases community support of day care as an effective resource and as support for the family.	8) Day care facilities and community resources be in close contact to increase the effective use of each other's resources.
9) Coordination of existing community resources serving the day care population allows informed, efficient, and effective use of those resources for children in day care and their families.	9) Coordination of resources serving the day care population be increased to improve communication, information exchange, and use of existing resources.
10) Consultation is basic to the generation and implementation of resource coordination and to the replication of the project's approach.	10) Available consultation resources in individual communities be used to coordinate resources and to increase the effectiveness of services for young children and their families.

APPENDIX 1

NUMBER AND TYPE OF DEVELOPMENTAL PROBLEMS FOUND USING THE DIAL, FOR EACH OF THE THREE PROJECT YEARS.

PROBLEM TYPE	YEAR																	
	1						2						3					
	Total	(A)[1]	(B)[2]	(C)[3]	Net	%[4]	Total	(A)[1]	(B)[2]	(C)[3]	Net	%	Total	(A)[1]	(B)[2]	(C)[3]	Net	%
Down by DIAL Criteria	8	0	2	0	6	5.3	22	5	1	1	15	6.4	31	0	2	8	21[5]	9.2
Down in 2 areas 2 Years in a Row	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2	.9
Down in Fine Motor and Concepts	0	0	0	0	0	0	3	0	0	0	3	1.3	6	0	0	0	6	2.6
Down in Fine Motor and Gross Motor	0	0	0	0	0	0	4	0	0	0	4	1.7	4	0	0	0	4	1.8
Down in Gross Motor and Concepts	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0
Down in Gross Motor Only	3	0	0	0	3	2.6	18	0	6	0	12	5.1	11	0	1	0	10	4.4
Down in Fine Motor Only	3	0	0	0	3	2.6	9	0	0	0	9	3.8	17	0	5	0	12	5.2
Down in Concepts Only	4	0	1	0	3	2.6	2	0	0	0	2	.8	3	1	1	0	1	.4
Totals	18	0	3	0	15	13.2	58	5	7	1	45	19.1	75	1	9	9	56	24.6

[1]English is second language
[2]Not reflective of ability
[3]ReDIAL--not down
[4]Percentages are based on the number of children screened with the DIAL each project year: 1=114; 2=236; 3=228.
[5]This figure includes two children who were down in fewer areas after a ReDIAL.

APPENDIX 2

PROJECT SERVICE DELIVERY APPROACHES TO CENTER GOAL AREAS

GOAL AREA	WORKSHOPS	RESOURCE MATERIALS	CONSULTATION
Social/ Emotional Development	Children's Feelings (Central) Cultural Awareness (Central) Children's Sexuality (Central) Curricular Activities Children's Behaviors Teacher Language (Centers A,C,D,F)	Workshop handouts Books on loan (Centers A&D) Booklist ("Different Books About Different Folks")	All
Health	Childhood Illnesses	Workshop Handouts Health and Developmental Intake Forms	Centers A,C,& E
Community Resources	Family Resource Panel (Central) Language Resource Panel (Central)	CCCRS Yellow Pages Dental Resources Resources gathered by project (Center B)	All
Parent Involvement	Family Resource Panel (Central) Communicating With Parents (Centers C, F)	Parent Activity Books Books on loan (Centers A, F) CCCRS videotape (Centers A,F) Health and Developmental Intake Forms	All
Fine Motor	Perceptual Motor (Central) Woodworking (Central)	Workshop handouts Books on loan (Center E) Parent Activity Books	Centers B,C,D,E
Gross Motor	Gross Motor (Central) Creative Movement (Central)	Workshop handouts (Centers C,D,F) Parent Activity Books Books on loan (Center E)	Centers C,D

APPENDIX 2 (CONTINUED)

PROJECT SERVICE DELIVERY APPROACHES TO CENTER GOAL AREAS

GOAL AREA	WORKSHOPS	RESOURCE MATERIALS	CONSULTATION
Staff Relations	Staff Relations (Center C) Staff Relations Follow-up (Center C)	Workshop handouts (Center C) Paper on Supportive Feedback (Centers C,E)	All
Record Keeping		Resources gathered by project	
Safety	First Aid (Centers C,F,F)	Workshop handouts Safety checklist	Center E
Nutrition	Nutrition	Workshop handouts	All
Sex Education	Children's Sexuality (Central)	Workshop handouts	All
Activities for the Autistic-Like Child	Autism	Workshop handouts	None
Using Foster Grandparents			All
Staffing Protocols			All
Parent Make It and Take It Workshop		Sources of possible activities Handouts for use at workshop	All
Procedures for Home Visits		Resources gathered by Project	All
Kindergarten Readiness	Gross Motor (Central) Perceptual Motor (Central) Woodworking (Central) Math & Science (Central) Rhythm (Central)	Workshop handouts Books on loan	All
Developmental Assessment	Developmental Assessment Gross Motor (Central)	Workshop handouts	None

APPENDIX 2 (CONTINUED)

PROJECT SERVICE DELIVERY APPROACHES TO CENTER GOAL AREAS

GOAL AREA	WORKSHOPS	RESOURCE MATERIALS	CONSULTATION
Other Central Workshops Offerred	Cooking Math & Science Socio-Dramatic Play Rhythm		
Workshops Offered to Centers Not Involved in Goal-setting	Center M: Gross Motor Baby Exercise Children's Books Food Policies Children's Sexuality Sensories Development Activity	Workshop Handouts	
	Center K: Gross Motor Pre-School Physical Fitness Perceptual Motor Manipulative Materials Math & Science Cooking Children's Feelings Children's Sexuality	Workshop Handouts	